MINISTRY OF HEALTH

IMPLEMENTATION GUIDELINES

FOR THE

HOME BASED MANAGEMENT

OF FEVER STRATEGY

(1st Edition March 2002)

WHO

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BASICS

CARE FOR OTHERS
DISH
CARE FOR YOURSELF

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FOREWORD

Malaria is a very important disease in Uganda. It is one of the most frequent causes of illness in homes leading not only to suffering but also to economic loss, as sick people do not work.

Most attacks of malaria are simple and uncomplicated. If treated promptly, full recovery of the patient, with no residual disabilities is expected. However, if treatment is delayed, uncomplicated malaria is likely to progress and become severe and complicated, in which case, death or residual disability is likely to occur.

Access to health care facilities, which have effective treatment for malaria, is still unsatisfactory in many places. Many people first treat themselves and their children at home. In many of these cases the drugs used are either of poor quality, wrong type or they are administered in incorrect dosages. The treatment at health facilities is usually sought only when home treatment has failed. This may be too late especially in children.

In response to this situation, the Ministry of Health together with its development partners have developed a strategy for improving home based management of fever/malaria. Safe and effective anti-malarial drugs for treatment of uncomplicated malaria will be made available within communities so that caretakers can quickly access them as soon as their children develop symptoms of malaria. The link between the community and the health facilities and the health facilities themselves will also be strengthened.

This document is a practical guide for implementation of the home-based management of fever strategy. It is a tool to be used by implementers of the strategy at the district, Health Sub district, health facility and community level.

I trust that you will find the document useful in implementation of this important strategy.

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List of Abbreviations

BASICS	Basic Support for Institutionalising Child Survival
DDHS	District Director of Health Services
DHMT	District Health Management Committee
DHT	District Health Team
DISH	Delivery of Improved Services of Health
HBM	Home Based Management
HC	Health Centre
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IMCI	Integrated Management of Childhood illnesses
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Net
LC	Local Council
MCP	Malaria Control Programme
MoH	Ministry of Health
NGO	Non Governmental Organization
PRA	Participatory Rural Appraisal
SP	Sulfadoxine-Pyrimethamine
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 Background

Malaria remains the leading cause of morbidity and mortality in Uganda, accounting for 46% of illnesses in children, 20-40% of outpatient visits, 25% of admissions to hospitals and 14% of inpatient deaths. Malaria and malaria-related illnesses contribute 20-23% of the infant and childhood mortality rates. Some of the reasons for this poor state include increased transmission of malaria in originally non-malarious areas, limited access to adequate treatment in the formal health facilities, increasing resistance of malaria parasites to drugs resulting in treatment failures and the rampant incorrect/inadequate treatment at home or within communities where the majority of people receive their first treatment for malaria/fever.

In the Abuja declaration of April 2000, the Africa Heads of State pledged to increase access to prompt and appropriate treatment, use of personal protective measures including ITMs and malaria chemoprophylaxis in pregnant women to 60% by 2005. The Health Sector Strategic Plan (HSSP) of the Ministry of Health has set similar targets for the period 2001 – 2005.

As a means to achieve the targets set in the declaration and sector plan, the ministry and its partners have developed and approved a strategy for home based management of fever. The strategy is expected to significantly contribute to the reduction of morbidity and mortality due to malaria in children under five years of age through improved community and home management of malaria.
The strategy is based on three key elements:

i. Communication for behaviour change
ii. Distribution of pre-packaged antimalarial drugs
iii. Strengthening the health facilities to manage patients referred from the communities.

The objectives of the strategy are:

I. To increase to 60% the proportion of children under five years suffering from fever/malaria who have access to pre-packaged antimalarial drugs at household level, by the end of 2003.

II. To increase to 50% the proportion of children who receive early appropriate treatment (with pre-packed Chloroquine and SP within 24 hours of onset of fever) for fever/malaria, at the household level, by the end of 2003.
III. To increase to 50% the proportion of children with severe fever illness that are promptly referred to formal providers, by the end of 2003
IV. To increase the proportion of health facilities that offer appropriate care to children with fever/malaria

Later the strategy will be used to increase uptake of IPT and ITNs.

The implementation principles include:

I. The strategy should be fully incorporated within the overall district health work plan and activities. Both the district health and political/administrative systems are key in the strategy implementation.
II. Although there is flexibility in approaches and districts will decide on how they will implement the strategy to achieve the objectives, it is recommended that the implementation should utilize existing community level programs and structures as much as possible.
III. Each village/local council 1 should have at least two volunteer drug distributors selected by the community members. The drug distributors should work closely with the health providers in nearby health facilities. They should get the drugs from these health facilities and submit reports to the health facilities. The health facilities should provide support to the drug distributors in form of training and supervision.
IV. The strategy emphasizes empowerment of caretakers particularly mothers to provide prompt and effective treatment of fever at home.

1.2 Aims and objectives of the document

This document provides guidance for implementation of the Home based management of fever strategy at the household, community, sub district and district levels.

Specifically, the document provides guidance for:

1. Sensitization of communities and health workers
2. Selection of drug distributors
3. Training of community drug distributors
4. Support supervision of community drug distributors
5. Monitoring implementation of the strategy

1.3 Layout of the document

This document is presented in four chapters:

Chapter 1 outlines the aims and objectives, intended users and implementation principles.

Chapter 2 describes the steps for sensitization of health workers, communities and the selection of drug distributors.

Chapter 3 details training of drug distributors.

Chapter 4 discusses supervision and monitoring of implementation.

In the annexes are the tools for use in implementation.

1.4 Intended users

The document is intended for use by:

I. District and HSD managers
II. Trainers of drug distributors
III. Supervisors of drug distributors

Refer to the relevant part of the document when conducting a given activity.

CHAPTER 2: SENSITIZATION OF HEALTH WORKERS AND COMMUNITIES

2.1 SENSITIZATION OF HEALTH WORKERS

2.1.1 Introduction

To create awareness and generate support for the strategy, all health workers in public and private health facilities should be sensitized. Such sensitization should be arranged as on-job training but can also take place in meetings organized at an appropriate level like the Sub County. It is important that health workers appreciate that the strategy is not intended to replace their services. They should work in partnership with the drug distributors rather than view them as competitors. For the strategy to succeed, health workers should recognise and support the work of the distributors to increase the communities' confidence in the distributors.

The objectives of this sensitization are to:

1. Introduce the HBM of fever strategy to health workers and explain their expected roles

2. Update health workers on the currently recommended malaria treatment.

The Expected out comes of the sensitization are:

- Acceptance of HBM of fever strategy and inclusion of activities in health facility work plans

- Malaria case management according to the recommended treatment guidelines

2.1.2 Sensitization Methods and Content

The sensitization should be done by the district trainers, through one-day orientation workshops arranged at the sub-county or HSD head quarters, and on-job training. At least one health worker from each health unit should be trained/sensitized. Remember to allow free discussions.

The sensitization should cover the following aspects:

I An overview of the strategy covering the topics in the Box 1 below. Details on the topics are provided in annex 1.

Box 1: Overview of HBM strategy

- Background information
- What the HBM strategy is
- Objectives of HBM strategy
- Evidence that HBM strategy works
- The primary beneficiaries
- Roles at different levels

II Roles of health workers and health units in the implementation of the strategy. These are outlined in Box 2 below.

Box 2: Roles of health workers and health units

- Storage of drugs in adequate amounts to replenish the drug distributors' stocks
- Participating in the training of the community drug distributors
- Management of patients referred by the drug distributors including reorganization of health services to give priority to the very sick
- Record keeping and reporting to the HSD and district level
- Supervision of the drug distributors

III. The recommended malaria treatment regimen. This is outlined in Box 3 below.

Box 3: Recommended malaria treatment regimen

First line drug: Chloroquine (CQ) and Sulfadoxine-Pyrimethamine (SP) combination

Second line drug: Quinine tablets

For severe malaria: Quinine injection

IV. Supervision and Monitoring of HBM covering the topics in Box 4 below. Details on the topics are provided in chapter 4 of the document.

Box 4 Supervision and Monitoring

- Aim and Objectives of supervision
- Supervisors
- Frequency of supervision
- Process of supervision
- Tools
- Indicators
- Reporting and information flow

2.2 SENSITIZATION OF COMMUNITIES

2.2.1 Introduction

Communities are expected to select and support drug distributors, take children who are sick for treatment and to comply with treatment instructions. It is therefore important that community sensitization and mobilization is properly carried out.

The sensitization should be carried out by a team comprising of community mobilizers and health workers from the nearby health facilities, with support from the district. The community mobilizers should be equipped with the necessary skills such as the IMCI tailored PRA course. The sensitization should be carried out at the village/LC1 level.

Objectives of sensitization

1. To increase awareness about malaria at community level
2. To introduce the Home Based Management of fever strategy
3. To stimulate early health care seeking behaviors
4. To guide the community to select drug distributors
5. To solicit for community support for the strategy

2.2.2 Sensitization Methods and Content

The sensitization should be done through village meetings/gatherings held at a time and venue agreed to by the village leaders during a pre-visit. The sensitization should follow the steps below:

I. Introduction

- Briefly explain the strategy to the local leaders as people gather for the bigger meeting. This will stimulate local political commitment and ownership of the strategy

- Allow the local council leaders to introduce the team to the community members and the purpose of the visit
- Ask the community to list the common diseases affecting children in their area. . If fever or malaria is mentioned, then use this as an entry point for your discussions. If fever/malaria is not mentioned, probe more about it as a way of starting your discussions

II. A presentation on malaria covering the topics in Box 1 below. Refer to annex 2 for the recommended answers.

Box 1: Malaria cause, signs, treatment and prevention

- Who is at risk of severe malaria?
- Why is malaria a very important disease
- How do you tell that a person has got malaria?
- How should you treat a child with malaria?
- How can we protect ourselves from malaria?

III. An overview of the HBM strategy as outlined in Box 2 below.

Box 2: Overview of HBM strategy

- Fever/malaria is a big problem in the country causing a lot of sickness and deaths
- Most fever/malaria patients are treated within the community with wrong drugs and doses
- Government has started a programme to provide proper treatment for fever/malaria at the community and household level
- The programme will start with children below five years but will later cover all ages
- Drugs will be in special packs called HOMAPAK: one type for children 2 months to 2 years and the other for children 2 to 5 years
- The drugs in this pack are a combination of Chloroquine and SP, which are recommended by Ministry of Health
- The drugs will be distributed by people you will select in this village/LCI
- The people you select will be trained to be able to perform their duties well
- The same drugs will be available in health facilities, pharmacies, drug shops and other retail outlets.
- Drugs from the community distributors will be provided free of charge but those from drug shops will be sold.

IV. Discussion of the Roles of the community

The expected roles of the communities in implementation of the strategy include:

- Selection of distributors,
- Collection of drugs from the nearest distribution point
- Motivation of drug distributors

V. Selection of drug distributors

Guide the selection of drug distributors. Remind the community members that a drug distributor is an important part of this strategy. He/she will serve as the point where the community members come for drugs when the children have fever. The distributor will serve as a volunteer.

The roles of the distributor will include:

- Treating children who have fever/malaria
- Identifying children who need to be referred to the health facilities and advising the caretakers on the need
- Educating mothers on the need for prompt treatment and compliance
- Follow up of the treated children to ensure that they comply with the treatment and advice
- Recording treatment given, its outcome and reporting to the nearest health facility
- Working with the community to collect drugs from the nearest health facility or distribution centre.

Each village (LC1) should select 2 drug distributors. (A higher number may be selected in very big villages or where people are hard to reach).

It is important that the right persons are selected as drug distributors. A suitable distributor should be:

- Easy to approach
- Trustworthy and reliable
- A permanent resident in the community
- Trainable (can read and write)
- Willing to work as a volunteer

Note:

- Avoid suggesting any names – just mention the above qualities to help the communities to make a good selection.
- Experience shows that in many areas **women serve as better drug distributors**.
- Take into consideration the location of the distributors in the community making sure that no areas are left under served.

The community should select the distributors during the meeting.

2.2.4 Things to keep in mind

The way and manner your team approaches the community will influence the success of this strategy.

Remember that when you have arranged a community/village meeting;

- It is very important that you arrive in time
- You should show respect to the local council leaders
- You should respect the local traditions and culture
- You should invite people to comment and ask questions throughout the meeting. Patiently respond to the comments and answer the questions as truthfully as you can.

It is important to avoid imposing your own ideas and promising what you are not able to do e.g. payment for drug distributors.

Conclude the sensitisation session by summarizing the major issues discussed.

CHAPTER 3: TRAINING DRUG DISTRIBUTORS

3.1 PLANNING FOR A COURSE

Training drug distributors is a crucial activity and if it goes wrong, the whole strategy may not succeed. It is therefore important to make sure that the activity is well planned giving particular attention to the trainers, training sites and training methods. The training of drug distributors should be carried out through a two-day course.

3.1.1 Trainers

A team of National facilitators will train district trainers selected from the DHT, HSD and Sub County. As much as possible, these district trainers should be the existing trainers for IMCI and Malaria. When selecting trainers both men and women should be included to make both female and male drug distributors feel comfortable during training.
It is recommended that a course of 30 – 35 participants should have at least three trainers. The criteria for selection of participants are covered in chapter 2.

3.1.2 Training sites

The choice of the venue is important. A place that is familiar and comfortable to drug distributors e.g. a parish or sub county headquarter or a nearby health facility should be used. There should be enough room for people to work in groups. Training at a health facility is preferable since it will allow drug distributors to practice giving the packs on actual patients.

3.1.3 Training materials: what do you need?

You should assemble the following materials at least two days before the course:

- Training guidelines for the trainers
- A note book/exercise book and a pen for each distributor
- Flip chart(s) and Markers
- A sample of pre-packs of the drugs to be used
- Registers and free treatment recording forms
- A set of job aides

You should take enough materials with you to the training site. It is usually safer to take at least three or four extra sets of materials for each course.

3.1.4 What should the distributor take home?

To be able to start activities immediately, it should be arranged that after the training each distributor goes home with the following items:

- A set of job aides
- A register
- A pen
- Enough packs of drugs for at least 1 month

3.2 TRAINING METHODS

Drug distributors are adult learners hence the principles of adult learning should be applied while teaching them.

- The learners' experiences are a major resource in a learning situation
- Adults are motivated to learn by a variety of factors; therefore discover these factors and capitalize on them.
- A comfortable, supportive environment is a key to successful learning e.g. physical factors, language used, character and dressing of the facilitator.
- Active participation in the learning process contributes to learning; therefore involve the learners
- Adults are a highly diversified group of individuals with widely differing preferences, experiences, needs, backgrounds and skills; therefore be observant and recognize their capabilities.

The following learning methods should be used:

1. Small group discussion
2. Role-play where there are no patients
3. Demonstration and return demonstration
4. Modified lecture/lecture

NB: The choice of a teaching method will be determined by:

- What you want to achieve
- The practicability of the method
- Availability of the required resources

Whatever method you choose, keep in mind that effective learning will take place when the teacher;

- Involves students (active learning)
- Is clear
- Checks for understanding
- Allows for individual differences and abilities
- Motivates the learners

3.3 TRAINING CONTENT

The training of drug distributors should cover the following essential areas:

I. Malaria, its importance, cause, signs, treatment and prevention
II. Overview of the home based management of fever strategy
III. Roles of a drug distributor
IV. Recognition of a child with fever
V. What to do for a child with fever
VI. Determining what pack to give
VII. What to tell the mother/caretaker
VIII. Recording the treatment
IX. How to keep drugs

3.3.1 Malaria, its importance, cause, signs, treatment and prevention

Use the information provided in annex 2 to discuss these topics.

3.3.2 Overview of the home based management of fever strategy

Use the information in Box 1 below to present an overview of the HBM strategy. Refer to annex I for more information if necessary.

Box 1: Overview of HBM strategy

- Fever/malaria is a big problem in the country causing a lot of sickness and deaths
- Most fever/malaria patients are treated within the community with wrong drugs and doses
- Government has started a programme to provide proper treatment for fever/malaria at the community and household level
- The programme will start with children below five years but will later cover all ages
- Drugs will be in special packs called HOMAPAK: one type for children 2 months to 2 years and the other for children 2 to 5 years
- The drugs in this pack are a combination of Chloroquine and SP, which are recommended by Ministry of Health
- The drugs will be distributed by people you will select in this village/LCI
- The people you select will be trained to be able to perform their duties well
- The same drugs will be available in health facilities, pharmacies, drug shops and other retail outlets.
- Drugs from the community distributors will be provided free of charge but those from drug shops will be sold.

3.3.3 Roles of a drug distributor

Discuss the roles of a drug distributor as outlined in Box 2 below.

Box 2: Roles of a drug distributor

- Treating children who have fever/malaria
- Identifying children who need to be referred to the health facilities and advising the caretakers on the need
- Educating mothers on the need for prompt treatment and compliance
- Follow up of the treated children to ensure that they comply with the treatment and advice
- Recording treatment given, its outcome and reporting to the nearest health facility
- Working with the community to collect drugs from the nearest health facility or distribution centre

Emphasize to participants that by being selected to serve as drug distributors, communities have put their trust in them and they should not fail their communities.

Discuss with participants how their communities intend to collect drugs from the nearest health facility/drug distribution centre.

3.3.4 Recognition of a child with fever

Fever simply means hotness of the body. A child should be taken to have fever if:

- The body is hot on touch
- The caretaker tells you that the child has fever or had fever before coming to you

NB: You should always believe what the caretaker tells you even if you can't feel the body hotness yourself.

A child with fever may also have the following signs: vomiting, refusal to feed, excessive sweating, not playing actively as usual

A child with fever may also have signs of **danger** or complications like:

- Convulsions
- Loss of consciousness
- Severe Anemia or "lack blood" shown by pale lips or palms
- Difficulty in breathing
- Extreme weakness (unable to sit or stand)

These signs are called **danger signs** and a child with any of the signs is in immediate danger of death. His/her case is a medical emergency, which needs immediate treatment in a health unit.
(Use local terms to describe these conditions as much as possible)

3.3.5 What to do for a child with fever

When a caretaker brings a child to you or comes to collect drugs for a sick child at home, always follow the following steps:

1. Ask the caretaker the child's problems – record this

2. Ask the caretaker the age of the child (If not sure, judge from the age of the siblings or use events like election time to estimate the child's age) - record this

3. Ask the caretaker if the child has any of the following signs:
   - Convulsions
   - Loss of consciousness
   - Vomiting everything / severe vomiting
   - Child not able to drink or breast feed
   - Very sick child (unable to sit or stand)
   - Difficulty in breathing

4. Determine if the child has been given Chloroquine and/or Fansidar before coming to you; if yes then refer.

The action to take will depend on the child's sickness:

A) A Child with fever and **no danger sign**

Treat the child with HOMAPAK and ask the caretaker to continue treatment at home.

If the child also has another illness like diarrhoea, cough, abscess, ear infection, etc give the caretaker HOMAPAK **but** ask the caretaker to take the child to a health facility.

B) A Child with fever and **a danger sign**

Refer the child immediately to the nearest health facility. The criteria for referral are outlined in Box 3 below.

NB. A child should not be given the HOMAPAK drugs more than once in a given month. This will avoid overdosing the child as the drugs stay for a long time in the body.

Box 3: Criteria for referral

1. A child with any "danger sign"
   - Convulsions
   - Loss of consciousness/coma
   - Vomiting everything / severe vomiting
   - Child not able to drink or breast feed
   - Very sick child (unable to sit or stand)
   - Difficulty in breathing

2. A child who has not improved or who is getting worse after treatment with HOMAPAK for 2 or more days and is brought back to you (the distributor)

3. A sick child brought to you who is less than 2 months or above 5 years of age

4. A child is brought to you without fever but other conditions like cuts, fractures or poisoning

The child who is referred but is not vomiting and can take drugs by mouth should be given HOMAPAK but should immediately be taken to the nearest health facility.

Note: Explain to participants that referring a child to a health facility does not mean that they have been defeated. Communities will appreciate their services better if they refer a child in time and the child survives than if they try to treat a very sick child and the child dies. Health facilities are there to support the distributors' work.

Before referral, you should counsel the caretaker on the severity of illness, need for referral, and the importance of getting the correct treatment at the health facility as soon as possible – you should also try to address the fears, questions or concerns of the caretaker regarding referral. However, this should not take a lot of time and delay referral.

3.3.6 Determining the pack to give

It is important to always make sure that the child receives the correct pack for his or her age. The type of pack depends on the child's age as shown in the table below.

Age	**Pack**	**Dosage**		
		Day 1	**Day 2**	**Day 3**
2 months to 2 years	RED	1 tablet of C/Q 1 tablet of SP	1 tablet of C/Q	1 tablet of C/Q
2 to 5 years	GREEN	1 tablet of C/Q 1 tablet of SP	1 tablet of C/Q	1 tablet of C/Q

Note:

- A tablet of Chloroquine (C/Q) in the Red pack contains 75mg chloroquine base and a tablet of SP in the same pack contains 250mg sulfadoxine and 12.5 mg pyrimethamine
- A tablet of Chloroquine (C/Q) in the Green pack contains 150mg chloroquine base and a tablet of SP in the same pack contains 500mg sulfadoxine and 25 mg pyrimethamine
- Although there are equal numbers of tablets in the two packs, they are of different strengths and should not be interchanged
- A child 2-6 months old should get ½ (37.5mg) of the chloroquine tablet on day 3.

Give participants the actual packs so that they are familiar with them. If the training is at a health facility let each participant practice giving out packs. If there are no patients, use role-plays.

Discuss with participants how to determine the age of a child when the caretaker is not sure; using main events like Christmas, elections or the age of another child in the family.

N.B You should treat all children even when they are from the neighboring village or they are visitors in your village.

3.3.7 What to tell a mother/caretaker

You should take sometime to advise the caretaker and provide information on the following:

A) How to give the HOMAPAK at home. Ask the caretaker to follow the steps below:

1. Crush the tablet and put the white powder on a spoon or in a small cup and mix it well with a small amount of clean water.

2. Give all the mixed drug to the child making sure that all the drug is swallowed.

3. Observe the child for the next 30 minutes and see if the child vomits the drug

4. If the child vomits the drug within this time, repeat the dose[1]

C) To complete all the doses (drugs) in the pack as instructed even when the child seems to have improved. Not to share out the packed drugs with other children.

D) The drugs are safe in the recommended doses. There may be itching and allergic reactions. If a skin reaction occurs take the child to a health facility immediately.

E) To keep the packs in a clean dry place away from children and not to open the pack unless the caretaker is going to give a dose.

F) To take the child to a health facility if:

- The child is not improving
- The child is becoming more sick
- Fever persists after 2 days of taking the drugs without vomiting them

G) A child who is referred should immediately be taken to a health facility without further delays

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[1] Discuss with participants mechanisms of making drugs available for this.

3.3.8 Recording the treatment

It is important that you record all the treatments that you give to children in your community. Proper record keeping will help you to know your progress, provide information for your community and help health workers to estimate your drug requirements.

You should record all the information on the treatment recording form - **annex 4.** These recording forms will be provided to you in form of a register. Supervisors will look at the records from time to time.

Practice filling the recording form with the participants. Enough time should be given to this exercise, as this is a very important part of the strategy. You may use role-plays or actual patients if you are at a health facility. This exercise may be combined with the session on determining what pack to give –3.3.6.

Note

- To determine whether a child has received the pack within 24 hours or after 24 hours of fever onset, first ask the caretaker the time of fever onset.

  -If the child receives (or caretaker comes for) the pack **before the same time** the following day, take this to be "within 24 hours"

  - If the child receives (or caretaker comes for) the pack **after the same time** the following day, take this to be "after 24 hours"

- Take a child to have an adverse reaction "Yes", if he develops a skin rash during the period of taking the HOMAPAK drugs. Itching or vomiting of drugs occurring alone without a skin rash should not be considered as a drug reaction. Some children may already have a skin rash from other causes before taking the drugs. Such a rash should not be confused with a drug reaction. Caretakers may describe a drug reaction in a local terminology like "swelling of the body". Try to understand what these terms mean.

- You can fill the outcome of treatment later. "Recovered" should be determined after 3 days when the HOMAPAK treatment is completed. "Referred" should be filled at the time you refer the child.

- Ask about adverse drug reaction and record this as you record the outcome of treatment.

- A child can have 2 different outcomes eg "referred" and "died" or "referred" and "recovered".

3.3.9 How to keep drugs

The quality of drugs will be badly affected if they are not well kept. The drugs will no longer treat the sick children well and the community will in turn lose trust in you.

It is therefore important that you keep the drugs in the following way:

- Select a dry clean place in the house where the drugs may be kept
- If the place is damp, keep the drugs in a cup board, box or on a hard material which does not allow water to pass through
- Keep the drugs away from extremes of heat and cold
- Keep the drugs away from direct sunlight
- Keep the drugs separate from the other items in the house
- Do not allow children to come near to or play with the drugs

You will be given drugs for about 1 month to go with after training. You will collect more drugs from the nearest health facility or distribution center.

Note: **Estimating the number of packs to give to a distributor**
First know the overall population of the LC1 from which the distributor comes. Take 20% of this population to be under five years. Assume that every child gets ½ an episode of fever in a month. This will give you the required packs in the LC1for one month. Give 40% of the total requirement as RED packs and 60% of the requirement as GREEN packs. Remember to divide the packs between 2 if the LC has two distributors!
Later the packs will be given out based on the actual consumption in the communities.

CHAPTER 4: SUPERVISION AND MONITORING

4.1 SUPERVISION OF ACTIVITIES

4.1.1 Introduction

Many activities will take place at district and lower levels during implementation of this strategy. To ensure quality and achievement of targets, these activities need to be supervised. The supervision should fit in the existing district supervision system and plans.

As you are aware, most health activities at community level are rarely supervised and the system is still weak. At the same time, most of the activities in this strategy will take place within communities. We should remember that drug distributors are lay people and should not be left on their own without support supervision from the health system. As health managers at district, HSD and health facility level, this presents a big challenge. We therefore have to work out a means of strengthening supervision at community level within our resources.

4.1.2 AIM OF SUPERVISION

The aim of this supervision should be to improve the quality of services provided by the drug distributors. This supervision should also strengthen linkages between the distributor, the community and the formal health sector and promote community participation.

The Objectives of the supervision should be:

- To strengthen the skills of the distributor for giving appropriate treatment and referral
- To support the distributors in proper drug storage and quantification
- To support the distributors in proper record keeping
- To support the distributors in solving problems related to their role of drug distribution
- To ensure that drug distributors stick to their expected roles and do not involve themselves in malpractices
- To promote community participation in the strategy

It is important from the beginning that the purpose for supervision is to support the work of the distributors and not fault-finding.

4.1.3 Supervisors

The primary supervisors of community health programs are staff of the health facility serving that community. However, a team involving an official from the local council, health assistants, dispensers, members from NGOs and religious leaders should be involved as much as possible. The HSD managers should make sure that all communities are covered by the supervision.

4.1.4 Frequency of supervision

Every distributor should be supervised from the nearest health facility at least once every quarter. Initially, every distributor should receive a monthly supervision as there may be more problems at the beginning. Quarterly supervision meetings should also be organized at the nearest health facility for all distributors. In addition, every advantage should be taken to discuss with the distributors technical issues of concern during their monthly visits to the health facilities to collect drugs. In addition, every opportunity should be taken to supervise distributors whenever a supervisor/health worker goes to a community for any other reason ie "no missed opportunity".

4.1.5 Process of supervision

Supervision should be well planned and every health facility should develop a supervision plan for drug distributors in its catchment area. Make sure all members of the supervision team are aware of the dates and the distributors to supervise. The distributor to be supervised should be informed of the supervisory visit in time.

Review the previous supervision reports (if any) and determine the areas to emphasize during this particular visit. Make sure the relevant supervision checklists/tools are available and any supplies (e. g. drugs, recording forms/registers) to deliver to the distributor are ready.

Try to get to the drug distributor at the appointed time and avoid keeping him/her waiting for you. When conducting the supervision be as interactive as possible and use the checklist in a supportive way. If you observe the distributor giving out a pack, acknowledge what he or she does well and in a friendly way make him/her aware of his weaknesses. Agree on areas of improvement. Take time to look at the distributor's records. Do not demand too much –remember the distributor is a volunteer!

The day-to-day supervision like ensuring that drugs are available and are used properly will be provided by the local leaders.

4.1.6 Tools: Use the checklist in **annex 3** during supervision visits. The checklist is only a reminder of the important areas to consider during supervision. There may be other aspects of importance for a given situation. Do not stick to the checklist and forget important steps like inquiring about the health of the distributor and his/her family!

4.1.7 Feedback and Reporting

Give direct verbal feedback to the distributor during the supervision process. If possible, hold a short meeting with the local council and members of the community to solve any problems you may have found. Write a brief clear report highlighting the problems/constraints identified, actions taken and your recommendations.

The report should be submitted to the nearest supervising health facility where it may be used for solving the problems you have identified and requesting support from higher levels.

4.2 MONITORING OF ACTIVITIES

4.2.1 Introduction

Monitoring of activities is an important part of this strategy and must be carefully carried out from the beginning of the implementation process.

It will help you to:

- Assess progress of activities eg training coverage, sensitization, drug distribution, etc
- Assess whether you are moving towards the set objectives
- Identify operational problems when they come eg stock outs, high drug distributor attrition rates etc

Monitoring will also help you to allocate and distribute resources in a more rational manner eg redistribution of drugs to areas where they are needed most.

For monitoring to be useful, it should lead to corrective action. This will require good information flow between the various levels of decision-making.

4.2.2 Indicators

A number of indicators are proposed for routine monitoring of activities at different levels. Refer to annex 10 for the indicators, their definition and level of collection.
You may need to add other indicators as appropriate to you. Also make an effort to monitor aspects such as community participation and integration of activities within overall community development.

The MCP will monitor the other specific areas like parasite resistance to drugs in conjunction with the relevant bodies.

4.2.3 Database and information flow

The following information should be kept and reported at the different levels:

A) Drug distributor
The distributor should keep data on the treatments given in the register –see annex 4. The distributor should carry the register along with him or her during drug collection visits to the health facility /distribution center. If another person apart from the distributor collects the drugs, he or she should still carry along the register from the distributor.

B) Health facility
All health facilities should keep a database on all drug distributors in their catchment area. Fill the drug distributors' summary form- annex 5, when distributors bring their registers during drug collection. The health facility will also keep supervision reports.

At the end of every month the data on the drug distributors' summary form should be compiled into a database using the format in annex 6. A copy of this database should be sent to the HSD by the 15th of the next month. The HSD should keep similar drug distributors' summary form and database for its immediate catchment area.
All supervision reports for a month should be summarized into one report using the format in annex 7. This is printed back-to back to the monthly report and will be sent together to the HSD.

C) Health Sub District
The HSD will receive monthly reports from all the health facilities. These should be summarized into one HSD database – annex 8. All supervision reports for the quarter should also be summarized into one report at the back of the HSD database form.

A copy of the HSD database should be sent as a report to the district by the 15th of the month following every quarter.

D) District

The district will receive quarterly reports from all HSDs. These should be summarized into one district database – annex 9. All supervision reports for the quarter should be summarized into one report at the back of the district database form.

A copy of the district database should be sent as a report to Ministry of Health, Malaria Control Programme by the end of the month following every quarter.

NB: Use the database to work out indicators proposed at your level. The indicators are defined in annex 10.

ANNEX 1 HBM STRATEGY OVERVIEW

1.0 Background information

- Malaria is a big health problem: 95% of the country experiences malaria all year around, 25-40% of outpatient attendance, 20% of admissions and 9-14% of deaths of in-patients is due to malaria.
- Households spend up to 10% of their monthly incomes on malaria treatment
- Access to proper malaria treatment is low: only 49% of the population lives within 5 Km of a formal health care facility. Up to 83% of fever cases are managed outside formal facilities (in communities/homes) in most cases with incorrect/incomplete doses, wrong drugs and often dangerous drug combinations
- The African Heads of State in April 2000 (in Abuja Nigeria) made a commitment that by 2005, at least 60% of malaria patients will have prompt access to appropriate treatment within 24 hours
- The Plan of the MOH is to increase from 30% to 60% the proportion of the population that receive effective treatment for malaria within 24 hours of the onset of symptoms by June 2005

Home Management of fever/malaria is already taking place but in an uncoordinated manner

Streamlining/improving home management of fever/malaria through the HBM strategy will help to achieve the objectives set by our Heads of State and the MOH strategic plan

2.0 What is the HBM strategy?

This is a MOH strategy that aims at contributing to the reduction of morbidity and mortality due to malaria in children less than five years of age through improved community and home management of malaria. This will be achieved through:

- Providing high quality pre-packaged drugs at the community and household level
- Making sure that each village/LC I has two trained drug distributors
- Mobilizing communities particularly mothers to seek care early and give appropriate home treatment
- Teaching both mothers and the drug distributors to recognize and refer children with severe illness in time
- Improving quality of care at health facilities by ensuring that drugs are available & staff are receptive

3.0 The objectives of the strategy are:

- To increase to 60% the proportion of children under five years suffering from fever/malaria who have access to pre-packaged antimalarial drugs at household level, by the end of 2003.
- To increase to 50% the proportion of children who receive early appropriate treatment (with pre-packed Chloroquine and SP

within 24 hours of onset of fever) for fever/malaria, at the household level, by the end of 2003.

- To increase to 50% the proportion of children with severe fever illness that are promptly referred to formal providers, by the end of 2003
- To increase the proportion of health facilities that offer appropriate care to children with fever/malaria

Later the strategy will be used to increase uptake of IPT and ITNs.

4.0 Is there evidence that the strategy works? Yes....

- In Ethiopia, an African country like Uganda, educating mothers and giving them chloroquine reduced deaths from malaria in children under 5 years by 40%
- In Burkina Faso another country similar to Uganda, this strategy reduced the prevalence of severe forms of malaria by 50%
- Here in Uganda, the strategy has been piloted in Mpigi, Masaka & Mubende districts and it has been shown that it is practicable and acceptable. During visits to these communities mothers reported that less children are dying from fever/malaria. A formal evaluation is not yet done.

5.0 Who are the primary Beneficiaries?

Children under five years of age estimated to be at 4.3 million and their mothers

6.0 What are the roles of the different levels

District/HSD	Health unit/Health workers	Community	Drug distributors
- Advocacy - Sensitization - Resource mobilization - Training of trainers - Training of supervisors - Drug distribution - Supervision - Monitoring	- Community mobilization - Training distributors -Storing drugs -Record keeping - Supervising distributors - Monitoring	-Selection of distributors, -Collection of drugs from the health facility, -Motivation of drug distributors	-Treating children with fever/malaria and advising mothers on compliance -Follow up of treated children to ensure that they comply with the treatment and advice -Identifying children who need to be referred to the health facilities and advising caretakers on the need -Record keeping and reporting to hospital -Working with the community to collect drugs from the nearest health facility

ANNEX 2 INFORMATION ON MALARIA

What causes malaria?

- Malaria is spread through the bite of a mosquito carrying malaria parasites
- Mosquitoes breed in stagnant water
- Rain increases stagnant water that serves as breeding sites for the mosquitoes. Usually there is an increase in malaria cases 1 to 2 months after the peak of the rainy season. Broken containers around compounds, and swamps also serve as breeding sites for the mosquitoes.
- Malaria is not caused by eating mangoes, maize, and sugarcane or by witchcraft or by spirits.

Who is at risk of severe malaria?

- Everybody can suffer from malaria but pregnant women and children less than five years are most at risk. In children and pregnant women malaria is usually more severe

Why is malaria a very important disease?

- Malaria kills more children than any other disease; most children who die of convulsions and anaemia ("lack of blood") have actually died of malaria
- Malaria is the leading cause of abortions and still births in pregnant women
- Families lose a lot of money on transport and treatment of the sick. They also miss gainful work.

How do you tell that a person has got malaria?

- Fever ("hotness of the body") is the commonest sign of malaria
- Other signs in children include vomiting, refusal to feed, excessive sweating, not playing actively as usual, etc.
- In adults signs may include headaches, joint pains, general body weakness, bitterness in the mouth, vomiting, loss of appetite, labour-like pains, dizziness and backache
- Malaria may also present as complications such as convulsions, loss of consciousness, very pale lips or palms (anemia or "lack blood"), difficulty in breathing, extreme weakness (unable to sit or stand) and abortions.

How should you treat a child with malaria/fever?

- Give a child with malaria/fever a combination of Chloroquine and SP (Fansidar) immediately you recognize that the child has fever
- Any sick child less than two months, a child who does not respond to Chloroquine & SP combination, or a child with any of the complications (danger signs) of malaria listed above should be taken to the nearest health facility

How can we protect ourselves from malaria?

- Children and pregnant mothers should sleep under an insecticide treated mosquito bed net to prevent them from contracting malaria
- When we are sick with malaria, we must receive prompt appropriate treatment to prevent death or disability. This particularly important for children.

ANNEX 3 SUPERVISION CHECKLIST

Drug storage and quantification

- Are the drugs stored in a dry, clean place?
- Has the distributor had any drug stock outs during the month?

Skills of the distributor

In case you witness a pack being distributed:

- Does the distributor give the correct packs for the child?
- Does the distributor counsel the caretaker to take appropriate action?

Record keeping and reporting

- Does the distributor fill the records properly?
- Did the distributor take with him/her records to the health facility/distribution center during the last drug collection?

Functioning of the drug distributor

What problems/constraints does the distributor face in carrying out his work?

Community involvement

- Are communities helping in collection of drugs?
- What is the community doing to motivate the drug distributor?

ANNEX 4 TREATMENT RECORDING FORM **Month /Year** ----------/----------

NO	Names of child	Age (years/ months)	Name & Relationship of caretaker to child	Pack given (Red/ Green/ None)	Interval from fever onset (Tick √)		Outcome (Tick √)			Adverse Drug Reaction (Yes/No)
					Within 24 hours	After 24 hours	Referred	Recovered	Died	
1										
2										
3										
4										
5										
6										
7										

ANNEX 5 DRUG DISTRIBUTORS' SUMMARY FORM **Month/Year** ----------/----------

Parameter	---------- **LC1**		---------- **LC1**		---------- **LC1**		---------- **LC1**	
	Distributor 1	Distributor 2	Distributor 1	Distributor 2	Distributor 1	Distributor 2	Distributor 1	Distributor 2
Number of children treated								
Number of Red packs given out								
Number of Green packs given out								
Number of children getting pack within 24 hours								
Number of children getting pack after 24 hours								
Number of children referred								
Number of children who recovered								
Number of children who died								
Any drug stock outs in the last one-month?								
Packs given out to the distributor								

ANNEX 6 **HEALTH FACILITY DATABASE FORM** **YEAR** ----------

Name of Health facility ..... No. of LC1s in catchment area ----------

	Month											
	J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Number of drug distributors in catchment area												
Number of distributors covered in this report												
Number of LCI with 2 or more drug distributors												
Number of children treated by distributors												
Number of Red packs given out												
Number of Green packs given out												
Number of children who receive pack within 24 hours of fever onset												
Number of children who receive pack after 24 hours												
Number of children referred												
Number of children who recovered												
Number of children who died												
Number of distributors with no drug stock outs in a given month												
Number of drug distributors who were supervised in a month												
Number of packs received from HSD												
Number of packs given out to the distributors												
Any stock out of HOMAPACK at the health unit? (Y/N)												

ANNEX 7 SUMMARY SUPERVISION FORM

Month /Year ----------/----------

No. of distributors in catchment area ----------

No. of distributors supervised ----------

Main problems/constraints identified

Actions taken

Recommendations

ANNEX 8 HEALTH SUB-DISTRICT DATABASE FORM **YEAR ----------**

Name of HSD..... No. of Health facilities in catchment ------ No. of LC1s in catchment area ----------

	Month											
	J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Number of drug distributors in catchment area												
Number of distributors covered in this report												
Number of LCI with 2 or more drug distributors												
Number of children treated by distributors												
Number of Red packs given out												
Number of Green packs given out												
Number of children who receive pack within 24 hours of fever onset												
Number of children who receive pack after 24 hours												
Number of children referred												
Number of children who recovered												
Number of children who died												
Number of distributors with no drug stock outs in a given month												
Number of drug distributors who were supervised in a month												
Number of packs received from district												
Number of packs given out to health facilities												
Number of health units with stock outs of HOMAPACK												

ANNEX 9 **DISTRICT DATABASE FORM** **YEAR ----------**

Name of District ..... No. of HSDs ---------- No. of health facilities ---------- No. of LC1s----------

	Month											
	J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Number of drug distributors in district												
Number of distributors covered in this report												
Number of LCI with 2 or more drug distributors												
Number of children treated by distributors												
Number of Red packs given out												
Number of Green packs given out												
Number of children who receive pack within 24 hours of fever onset												
Number of children who receive pack after 24 hours												
Number of children referred												
Number of children who recovered												
Number of children who died												
Number of distributors with no drug stock outs in a given month												
Number of drug distributors who were supervised in a month												
Number of packs received from MOH												
Number of packs given out to HSDs												
Number of health units with HOMAPAK stock outs?												

ANNEX 10 INDICATORS FOR ROUTINE MONITORING

INDICATOR	DEFINITION	LEVEL
1. Proportion of Sub counties sensitized on the strategy	Numerator: number of sub counties in district Sensitized on HBM strategy Denominator: Total number of sub counties in district	DISTRICT
2. Proportion of LC1 sensitized on the strategy	Numerator: number of LC 1 in catchment area sensitized on HBM strategy Denominator: Total number of LC1 in catchment area	HEALTH FACILITY HSD
3. Proportion of Sub counties with at least 2 trainers	Numerator: number of sub counties in district with 2 Or more trainers Denominator: Total number of sub counties in district	HSD
4. Proportion of LC 1 with at least 2 drug distributors	Numerator: number of LC 1 in catchment area with two or more drug distributors Denominator: Total number of LC1 in catchment area	HEALTH FACILTY HSD
5. Proportion of health units with no HOMAPAK drug stock outs in a month	Numerator: number of health facilities in HSD which had no HOMAPAK stock out in a given month Denominator: Total number of health units in the HSD	HSD
6. Proportion of health units with no quinine tablet stock outs in a month	Numerator: number of health units reporting no Quinine tablet stock out in a given month Denominator: Total number of health facilities reporting in the month	HSD, DISTRICT
7. Proportion of drug distributors with no drug stock outs in a month	Numerator: number of drug distributors in catchment area who had no HOMAPAK stock out in a given month Denominator: Total number of drug distributors in catchment area	HEALTH FACILITY HSD

INDICATOR	DEFINITION	LEVEL
8. Proportion of drug distributors who receive a monthly supervision	Numerator: number of drug distributors in catchment area who were supervised in a given month Denominator: Total number of drug distributors in the catchment area	HEALTH FACILITY HSD
9. Attrition rate of drug distributors	Numerator: number of distributors lost (not working) at the end of the year Denominator: number of drug distributors trained in a year	HEALTH FACILITY HSD, DISTRICT
10. Number of children treated by drug distributors	Number of children between 2 months and 5 years who are treated and recorded by the distributors in the catchment area	HEALTH FACILITY HSD
11. Proportion of sick children who receive HOMAPAK within 24 hours of fever onset	Numerator: number of children treated by drug distributors with HOMAPAK within 24 hours of fever onset Denominator: Total number of children treated by drug distributors	HEALTH FACILITY HSD
12. Proportion of children treated by distributors who are referred	Numerator: number of children referred by drug Distributors in the catchment area Denominator: total number of children treated by Drug distributors in the catchment area	HEALTH FACILITY HSD
13. Proportion of children treated by distributors who die	Numerator: number of children who are recorded by the distributors to have died Denominator: Total number of children treated by drug Distributors	HEALTH FACILITY HSD
14. Proportion of health facilities reporting in time	Numerator: number of health facilities in the HSD which report by 15th of the following month Denominator: total number of health facilities in the HSD	HSD
15. Proportion of HSDs reporting in time	Numerator: number of HSD in the district which by end of The month following a given quarter Denominator: total number of HSDs in a district	DIST

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